NASOTRACHEAL INTUBATION

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Possible cervical spine injury with clenched jaw and gag reflex.

2. Trapped and inaccessible for direct laryngoscopy.

3. Severe respiratory distress per Protocol Reference #11010, Adult Respiratory Emergencies.

4. Patient nare is able to accommodate size 7.0, 7.5 or 8.0 endotracheal tubes.

ABSOLUTE CONTRAINDICATIONS

Apnea.

RELATIVE CONTRAINDICATIONS

Base Station Contact Required

1. For significant trauma to the face or nose and/or possible basilar skull fracture.

2. For patients on anticoagulant therapy.

1. Suspected airway burns.

2. Failed CPAP.

PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts and explain the procedure to a conscious patient.

2. Immediately prior to intubation, consider prophylactic Lidocaine 1.5mg/kg IVP for suspected head/brain injury.

3. Select the nostril to be used and inspect for patency and air flow. Select the appropriate cuffed tube and pre-oxygenate patient with 100% oxygen prior to attempting procedure.

a. If patient becomes apneic, discontinue procedure and attempt oral intubation.

b. Lubricate the distal tip of endotracheal tube with a water soluble jelly or viscous Lidocaine.

c. Position the patient as tolerated. Hold in-line cervical stabilization if neck injury is suspected.

d. Administer one (1) metered dose, 0.5mg of phenylephrine HCL to the selected nostril. May be repeated once prior to additional attempt.

e. With one hand, advance ET tube into the selected nostril with bevel facing out while applying cricoid pressure with the other hand. Monitor breath sounds continuously with Beck Airway Airflow Monitor (BAAM) while gently guiding the tube into the trachea.

f. Inflate the balloon with air and ventilate with 100% oxygen. Secure the ET tube.

g. Verify and document tube placement.

h. Monitor end-tidal CO_2, wave form capnography and/or pulse oximetry during procedure.

i. Suction the trachea when necessary.

4. Contact Base Station if unable to place ET tube after a maximum of three (3) nasotracheal intubation attempts or if unable to adequately ventilate patient via BVM.

DOCUMENTATION

In the event the receiving physician discovers the device is improperly placed, an Incident Report must be completed by the receiving hospital and forwarded to ICEMA within twenty-four (24) hours of the incident. Forms are available as part of the protocol manual and on the ICEMA website.